11885

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Riva
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General	STREET ADDRESS (If rural, give location) Riva Post Office

3. NAME OF DECEASED (Type or Print)	(First) JOHN	(Middle) H	(Last) AISQUITH	4. DATE OF DEATH	(Month) Dec. 27, (Day) 1950 (Year) 19
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 26, 1873	9. AGE last birthday 77 yrs.	If under 1 year Months 9 Days 1; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-Farmowner	10b. KIND OF BUSINESS OR INDUSTRY Tobacco Farm	11. BIRTHPLACE (State or foreign country) Anne Arundel County, Md.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George Aisquith	14. MOTHER'S MAIDEN NAME Mary Ireland				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Edward F. Aisquith Riva, Md. (Son)			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Gen. carcinomatosis	4 hrs.
151X Antecedent cause(s)		
46b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of stomach	1 yr
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Oct. 50	19b. MAJOR FINDINGS OF OPERATION Carcinoma of stomach - pyloric region	20. AUTOPSY? Yes ☒ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1950, to Dec 27, 1950, that I last saw the deceased alive on 12/27, 1950, and that death occurred at 10 40 a m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
S. Bossuch MD		Annapolis Md	12/27/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 12-30-50	NAME OF CEMETERY OR CREMATORY Davidsonville Methodist	LOCATION (City, town, or county) (State) Davidsonville, Maryland
DATE REC'D BY LOCAL REG. Dec. 29, 1950	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR B.L. Hopping and Son	ADDRESS Annapolis, Md

000VV

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

11886

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY AA Odenton, Md. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (in this place) 3 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY AA
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) WILLIAM (Middle) THOMAS (Last) BELT

4. DATE OF DEATH (Month) 12- (Day) 23 (Year) 1950

5. SEX M

6. COLOR OR RACE Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH 9-11- 1900

9. AGE last birthday 50 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Finisher

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Odenton

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Henson Belt

14. MOTHER'S MAIDEN NAME Lillie Mae Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Eugenie Dorsey

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

911.3

Immediate cause (a) Pulmonary Embolism

186.b

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Comminuted Fracture Right Tibia and Fibular

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 12-7-50

19b. MAJOR FINDINGS OF OPERATION Fracture of the right tibia and fibula

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Factory (CITY OR TOWN) Odenton, Maryland (COUNTY) (STATE)

TIME OF INJURY (Month) 12-4-50 (Day) (Year) (Hour) P m.

INJURY OCCURRED While at Work ☒ Not While At work ☐

HOW DID INJURY OCCUR? Caught rt. leg between box-car and pile of bricks.

22. I hereby certify that I attended the deceased from 12-4- , 1950 , to 12-23- , 1950 , that I last saw the deceased alive on 12-22- , 1950 , and that death occurred at 8:30 A. m., from the causes and on the date stated above.

SIGNATURE Charles R. Weidenhammer (Degree or title) M.D. ADDRESS 7 Central Ave. Glen Burnie, Md. DATE SIGNED 12-23-50

23. BURIAL, CREMATION REMOVAL (Specify) B | DATE THEREOF 12-26-50 | NAME OF CEMETERY OR CREMATORY Mt Tabor | LOCATION (City, town, or county) (State) Chesterfield, Md.

DATE REC'D BY LOCAL REG. Dec. 26, 1950 | REGISTRAR'S SIGNATURE K. M. Joyce

24. FUNERAL DIRECTOR William Reese II ADDRESS 108 Washington Annapolis, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

1. PLACE OF DEATH: COUNTY Annapolis, AA MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 106 Clavert Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE | COUNTY AA
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) William (Middle) H. (Last) Brown
4. DATE OF DEATH (Month) 12 (Day) 31 (Year) 1950
5. SEX M
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 10-25-1880
9. AGE last birthday 70 yrs. | If under 1 year Months | Days | If under 24 hrs. Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cook
10b. KIND OF BUSINESS OR INDUSTRY Bureau of Navigation Inspt
11. BIRTHPLACE (State or foreign country) Annapolis AA Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Mary ~~Anne~~ Gantt
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Florence Brown

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
410x	Immediate cause	(a) Cardiac Failure	2 days
92 b	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Mitral Insufficiency	2 yrs.
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/29/50, 19....., to 12/31/50, 19....., that I last saw the deceased alive on 12/31/50, 19....., and that death occurred at 9:45 A.M. m., from the causes and on the date stated above.

SIGNATURE Theodore H. Johnson M.D. (Degree or title) ADDRESS 40 Northwest Street DATE SIGNED 1/1/51

23. BURIAL, CREMATION REMOVAL (Specify) B | DATE THEREOF 1-3-51 | NAME OF CEMETERY OR CREMATORY Brewer Hill Cemetery | LOCATION (City, town, or county) Annapolis AA Md. (State)

DATE REC'D BY LOCAL REG. Jan. 3, 1951 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR William ReeseII | ADDRESS 108 Washington Annapolis, Md.

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JAN 4 1951
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ft. Geo G. Meade, Md.
LENGTH OF STAY (in this place) 2 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. ARMY HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Georgia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Columbus
STREET ADDRESS (If rural, give location) Unknown ✓

3. NAME OF DECEASED (Type or Print) (First) John (Middle) W. (Last) Caulfield
4. DATE OF DEATH (Month) December (Day) 18 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH October 5, 1899
9. AGE last birthday 51 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk U. S. Government
10b. KIND OF BUSINESS OR INDUSTRY U. S. Army
11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Anne Driver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. I & II
16. SOCIAL SECURITY No. 433-40-0826
17. INFORMANT AND ADDRESS Mrs Nora Caulfield 566 Lambert St Meade Dale, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.1	Immediate cause	(a) Ventricular Tachycardia	2 hours
93d	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Myocardial Infarction with Congestive heart failure	6 months
		(c) Hypertensive cardio vascular disease	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 23 Oct, 1950, to 18 Dec, 1950, that I last saw the deceased alive on 18 Dec, 1950, and that death occurred at 1000 hours, from the causes and on the date stated above.

SIGNATURE Gerald M Trump (Degree or title) Bd Mc ADDRESS St Hosp Ft Meade DATE SIGNED 18 Dec 50

23. BURIAL, CREMATION REMOVAL (Specify) Removal
DATE THEREOF 18 Dec 50
NAME OF CEMETERY OR CREMATORY Unknown
LOCATION (City, town, or county) Columbus (State) Georgia

DATE REC'D BY LOCAL REG. 18 Dec 50
REGISTRAR'S SIGNATURE E.K. BURNSIDE, Capt. MSC
24. FUNERAL DIRECTOR Lilly & Zeiler, Inc. ADDRESS Baltimore, Md.

26697

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 20 1950
BUREAU V. S

Dr Basil

11889

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN West Annapolis
STREET ADDRESS (If rural, give location) 601 Monterey Ave

3. NAME OF DECEASED (Type or Print) (First) JOHN (Middle) P (Last) COLLINS

4. DATE OF DEATH (Month) DECEMBER (Day) 6, (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH June 10, 1884
9. AGE last birthday 66 yrs. If under 1 year Months 4 Days 26 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US Gov. Ret.
10b. KIND OF BUSINESS OR INDUSTRY Enginman
11. BIRTHPLACE (State or foreign country) Annapolis, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Collins
14. MOTHER'S MAIDEN NAME Katherine Terry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 220-24-2269
17. INFORMANT AND ADDRESS Mr Albert D. Collins Severna Park, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage with rt. hemiplegia	12-3-50
422.2 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Myocarditis ch. with Myocardial Insufficiency	3 years
93d	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis — Small Gen

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 25, 1950, to Dec 6, 1950, that I last saw the deceased alive on Dec 6, 1950, and that death occurred at 5 A m., from the causes and on the date stated above.

SIGNATURE George C Basil (Degree or title) M D. ADDRESS Annapolis Md DATE SIGNED 12-7-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 12-8-50
NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery
LOCATION (City, town, or county) Annapolis, Maryland (State)

DATE REC'D BY LOCAL REG. Dec. 7, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR B.L.Hopping and Son ADDRESS Annapolis, Maryland

32297

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 8 1950
BUREAU U. S.

11890

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrills
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 175

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Kentucky COUNTY Jefferson
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Louisville
STREET ADDRESS (If rural give location) 1736-B - Patton Court

3. NAME OF DECEASED (Type or Print) (First) Corporal (Middle) Harold Junior (Last) Conrad.
4. DATE OF DEATH (Month) Dec. (Day) 15 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify) Single
8. DATE OF BIRTH 9/16/29
9. AGE last birthday 21 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Corporal - U.S. Army.
10b. KIND OF BUSINESS OR INDUSTRY Bank Clerk
11. BIRTHPLACE (State or foreign country) Louisville - Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Harold E. Conrad
14. MOTHER'S MAIDEN NAME Loretta Alice Groneu

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Is now. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 402-32-9023
17. INFORMANT Fort Meade Records. -

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral hemorrhage due to fractured — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) skull. - Other hemorrhages due to fractured

(c) right wrist and multiple lacerations (of face.

816.5

170 c

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Route 175 - (CITY OR TOWN) Gambrills, (COUNTY) A.A. (STATE) Md.
TIME OF INJURY (Month) 12 (Day) 15 (Year) 1950 (Hour) 7:15 a.m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? Hit the rear of a trailer truck.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Gustave H. Pauber M.D. (Degree or title) assistant medical Examiner. ADDRESS Glen Burnie, Md. DATE SIGNED 12/15/50

23. BURIAL, CREMATION REMOVAL (Specify) Removal
DATE THEREOF 16 Dec 1950
NAME OF CEMETERY OR CREMATORY Unknown
LOCATION (City, town, or county) Louisville (State) Kentucky

DATE REC'D BY LOCAL REG. 16 Dec 50
REGISTRAR'S SIGNATURE E.K. BURNSIDE, Capt. MSC
24. FUNERAL DIRECTOR Lilly & Zeiler, Inc. ADDRESS Baltimore, Md.

60896

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

DEC 20 1950

Evidence for change of #9 shown on:
FILM No. G 1 1 FEB 27 1951

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

11891

Reg. Dist. No. 26

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shady Side
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shady Side
STREET ADDRESS (If rural, give location) Rural

3. NAME OF DECEASED (Type or Print) (First) JAMES (Middle) EDWARD (Last) CROWNER
4. DATE OF DEATH (Month) DEC. (Day) 23. (Year) 1950
5. SEX MALE
6. COLOR OR RACE NEGRO
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH SEPT. 27, 1872
9. AGE last birthday 78 ~~77~~ yrs. If under 1 year Months Days If under 24 hrs Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman
10b. KIND OF BUSINESS OR INDUSTRY Fish + oysters
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY U.S.A
13. FATHER'S NAME JOHN CROWNER
14. MOTHER'S MAIDEN NAME RACHAEL DENNIS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.
16. SOCIAL SECURITY No. —
17. INFORMANT AND ADDRESS CARRIE CROWNER, Shady Side Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
422.2 Immediate cause	(a) Acute Dilatation of Heart	Sudden
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic myocarditis	18 months
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Caffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md. DATE SIGNED 12/23/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Dec. 27 1950
NAME OF CEMETERY OR CREMATORY St. Matthews
LOCATION (City, town, or county) Shadyside, (State) Md.

DATE REC'D BY LOCAL REG. Dec. 27, 1950
REGISTRAR'S SIGNATURE J. B. Dent.
24. FUNERAL DIRECTOR J. B. Johnson ADDRESS

900 U1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JAN 3 1951
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11892

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH COUNTY A. A.	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrills LENGTH OF STAY (in this place) MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrills
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary	Jane	Dorsey	Dec.	29	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	Colored	widow	June 26 1842	108 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Prince George Co	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Duckings	Rachel Duckings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
		Mrs. Lillian Green

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420.0 Immediate cause	(a) Arterio sclerotic Heart Disease	10 Years.
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized Arterio sclerosis	
	(c) Old Age.	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct ....., 1946, to Dec 29 ....., 1950 that I last saw the deceased alive on Dec 28 ....., 1950, and that death occurred at 4:40 A ....m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Edward J Chenoweth	M.D.	Gambrills Md	12-31-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Jan 2 1951	Mt Tabor	Chesterfield	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 1, 1951	K. M. Joyce	J. B. Johnson	Annapolis.

RECEIVED
JAN 6 1951
BUREAU OF

11893

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 22

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton
LENGTH OF STAY (in this place) 7 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Watts Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton
STREET ADDRESS Watts Ave. (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) EDITH (Middle) MAE (Last) DUFF
4. DATE OF DEATH (Month) December (Day) 25 (Year) 1950
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Feb. 17, 1908
9. AGE last birthday 42 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edwin R. Nutter
14. MOTHER'S MAIDEN NAME Ida Mae Baker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 212-30-4838
17. INFORMANT Bernard Duff

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
023x Immediate cause	(a) Myocardial infarct due to stenosis of ostia of coronary arteries (023)	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 30 e	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work [ ] Not while at work [ ]
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ] thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

SIGNATURE Stanley H. Durlacher (Degree or title) M.D. ADDRESS 700 Fleet St., Baltimore 2, Md. DATE SIGNED Dec. 26, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Cremation
DATE THEREOF 12/28/50
NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory
LOCATION (City, town, or county) Washington D.C. (State)
DATE REC'D BY LOCAL REG. Dec 28-50
REGISTRAR'S SIGNATURE Clara Keaslup
24. FUNERAL DIRECTOR De Witt Donaldson ADDRESS Laurel, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JAN 10 1951
BUREAU V. S.

Fadum

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11894

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Linthicum Heights
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 108 S. Hammonds Ferry Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Linthicum Heights
STREET ADDRESS (If rural, give location): 108 S. Hammonds Ferry Rd.

3. NAME OF DECEASED (Type or Print): (First) LOUISE (Middle) (Last) FADUM

4. DATE OF DEATH: (Month) Dec. (Day) 8 (Year) 1950

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: May 5, 1857

9. AGE last birthday: 93 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: August Albrecht

14. MOTHER'S MAIDEN NAME: Augusta Saunders

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT AND ADDRESS: Mrs. Elma Peters - 206 S. Hammonds Ferry Rd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cardio-Vascular Disease	1 mo.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebro-Sclerosis	5 yr.
422.1 932	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐:

HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from Nov. 30, 1950, to Dec. 8, 1950, that I last saw the deceased alive on Dec. 8, 1950, and that death occurred at 1:30 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Chas. L. Bolle Jr.	M.D.	Linthicum	12/8/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	12/11/50	St. Pauls Cem.	Druid Hill Pk., Balto., Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
December 9th 1950	R.W.	Wm. J. Tickner & Sons	Balto Md.

11895

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 63 Franklin

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 63 Franklin

3. NAME OF DECEASED (Type or Print) (First) LILLIAN (Middle) (Last) FAIRFAX

4. DATE OF DEATH (Month) 12 (Day) 16 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED~~ (Specify)
8. DATE OF BIRTH Unknown 1892
9. AGE last birthday about 65 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No. —
17. INFORMANT AND ADDRESS Mrs C. Marshall Barton Jr. Balto Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	unknown
	(c)	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy M.D., Deputy Medical Examiner (Degree or title) ADDRESS Annapolis Md DATE SIGNED 12/18/50

23. ~~BURIAL~~, CREMATION ~~REMOVAL (Specify)~~ DATE THEREOF 12-19-50 NAME OF CEMETERY OR CREMATORY Ft Lincoln LOCATION (City, town, or county) Washington D.C. (State)

DATE REC'D BY LOCAL REG. Dec. 19, 1950 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

52086

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
DEC 21 1950
BUREAU W. S

MARYLAND STATE DEPARTMENT OF HEALTH

11896

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis (Rural) LENGTH OF STAY (in this place) 1 yr
HOSPITAL OR INSTITUTION OR STREET ADDRESS Riva Rd. RFD # 1

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) Riva Rd. RFD # 1

3. NAME OF DECEASED (Type or Print) (First) BENJAMIN (Middle) FRANCIS (Last) GARNER

4. DATE OF DEATH (Month) December (Day) 25 (Year) 50 19

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Sept 8, 1889
9. AGE last birthday 61 yrs. If under 1 year Months 3 Days 17 If under 24 hrs Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY Building
11. BIRTHPLACE (State or foreign country) Anne Arundel Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Benjamin Garner
14. MOTHER'S MAIDEN NAME Virginia Drury

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 212-14-9522
17. INFORMANT AND ADDRESS Mrs Frances Virginia Garner Riva Rd. RFD # 1 Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Suicide by hanging

974X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

164a (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY X OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at Home (CITY OR TOWN) RFD #1 Annapolis (COUNTY) Anne Arundel (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) Dec. 25, 1950 6p m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Hanged himself by neck

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

SIGNATURE John M. Clapley M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Maryland DATE SIGNED 12-25-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 12-28-50
NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery
LOCATION (City, town, or county) (State) Glen Burnie, Maryland

DATE REC'D BY LOCAL REG. Dec. 27, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR B.L. Hopping and Son ADDRESS Annapolis, Md.

60896

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

DEC 29 1980

11897

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural - Hanover
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Box 63 - B. Hanover, P.O.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Hanover
STREET ADDRESS (If rural, give location): Box 63 - B Hanover P. O

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) (Last) Goode
4. DATE OF DEATH (Month) Dec. (Day) 4 (Year) 1950

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: June 6, 1894
9. AGE last birthday: 56 yrs. If under 1 year Months. Days. If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Grayson.
14. MOTHER'S MAIDEN NAME: Rosie Bowie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT AND ADDRESS: Louis Goode. Stony Run Road Shipley Heights.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Hemorrhage

138.0 Antecedent cause(s)

562 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Sarcoidosis — Unknown.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify):
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 28, 1950, to Dec. 2, 1950, that I last saw the deceased alive on Dec. 2, 1950, and that death occurred at 1:00 A. m., from the causes and on the date stated above.

SIGNATURE: Ronald R Lighthalow (Degree or title) M.D. ADDRESS: 501 Cherry Hill Road. Balto. DATE SIGNED: 25 Md

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 12-7-1950 — NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem. — LOCATION (City, town, or county): Balto. (State): Md

DATE REC'D BY LOCAL REG.: 12/7/50 — REGISTRAR'S SIGNATURE: A. W. Hedrick — 24. FUNERAL DIRECTOR: Mrs Katie R Williams — ADDRESS: 322 N Schroeder St

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

mw

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

11898

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 1 hour
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HARWOOD
STREET ADDRESS (If rural, give location) RURAL

3. NAME OF DECEASED (Type or Print) (First) AMOS (Middle) (Last) HARDESTY

4. DATE OF DEATH (Month) DEC. (Day) 25 (Year) 1950

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH Mar. 4. 1873
9. AGE last birthday 77 yrs. If under 1 year Months Days If under 24 hrs Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Farmhand
10b. KIND OF BUSINESS OR INDUSTRY FARMING
11. BIRTHPLACE (State or foreign country) Calvert Co Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME James D. Hardesty
14. MOTHER'S MAIDEN NAME Sarah E. Hardesty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No. no
17. INFORMANT AND ADDRESS Richard Ward Deale, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) FRACTURE OF SKULL	2 HOURS
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) HIT-BY-AUTOMOBILE	
	(c)	

812.5
170c

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY WOODLAND Beach
(CITY OR TOWN) EDGEWATER (COUNTY) A.A. (STATE) MD.
TIME OF INJURY (Month) DEC. (Day) 25 (Year) 1950 (Hour) 5 to 8 A.M.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? STRUCK-BY-AUTOMOBILE

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Caffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md. DATE SIGNED 12/25/50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE THEREOF DEC 27-50
NAME OF CEMETERY OR CREMATORY Mt Harmony
LOCATION (City, town, or county) Calvert Co (State) Md

DATE REC'D BY LOCAL REG. Dec. 26, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR E. A. Hardesty & Son ADDRESS
866VV Galesville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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RECEIVED
DEC 27 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

11899

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md.
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. Co General

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pines on the Severn
STREET ADDRESS (If rural, give location) Arnold Md.

3. NAME OF DECEASED (Type or Print) (First) Alto (Middle) Ruth Shannon (Last) Heisler
4. DATE OF DEATH (Month) 12 (Day) 2 (Year) 1950

5. SEX F
6. COLOR OR RACE W
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH Apr. 6. 1896
9. AGE last birthday 54 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales lady
10b. KIND OF BUSINESS OR INDUSTRY SHOE DEPT
11. BIRTHPLACE (State or foreign country) Howard Kan.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME William D. Shannon
14. MOTHER'S MAIDEN NAME Margaret H. Mayne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 509-18-3388
17. INFORMANT AND ADDRESS Walter L. Heisler Pines on the Severn

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.1	Immediate cause	(a) Coronary Thrombosis	11.30.50
61	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio Sclerosis Moderate	unknown
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — unknown

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11.30, 1950, to 12.2, 1950, that I last saw the deceased alive on 12.2, 1950, and that death occurred at 5 p m., from the causes and on the date stated above.

SIGNATURE George C. Basil (Degree or title) M D ADDRESS Annapolis Md. DATE SIGNED 12. 4. 50

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify)
DATE THEREOF 12-6-50
NAME OF CEMETERY OR CREMATORY Asbury Cemetery
LOCATION (City, town, or county) Arnold (State) Md

DATE REC'D BY LOCAL REG. Dec. 6, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Taylor Sen. ADDRESS Annapolis Md.

27889

260x

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 7 1950
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11980

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN; LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS LOMBARDEE BEACH

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD; COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GLEN BURNIE P.O.
STREET ADDRESS (If rural, give location) LOMBARDEE BEACH

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JOHN	C.	HETTCHE	12	5	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
M	W	WIDOWED	DEC. 24 1870	80 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
TIN SMITH	SELF.	BALTIMORE, MD	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN HETTCHE	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
—	—	—	MR. WALTER F. CHAMBERS - Box 256A LOMBARDEE BEACH, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause:	(a) Uremia	24 hrs
4142X 1310 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio - Sclerotic Cardio-Vascular Renal Disease	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Dec. 1, 1950, to Dec. 5, 1950, that I last saw the deceased alive on Dec. 2, 1950, and that death occurred at 4:20 A.M. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Paul Lubin	M.D.	320 Patapsco Ave.	Dec. 6-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	12/7/50	WESTERN	EDMONDSON AVE.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
12/7/50	A. W. Hessman	JOHN F. DENNY, Inc	715 LIGHT ST. - 30

J1

42629

Evidence for changes in 18 & 21 shonw on:

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Evidence for addition of #9 shown on:

11901

FILM No. G 130 FEB 19 1951

FILM No. G 131 FEB 27 1951

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS
STREET ADDRESS (If rural give location) 37 WEST

3. NAME OF DECEASED (Type or Print) (First) BESSIE (Middle) W (Last) HOFFMAN

4. DATE OF DEATH (Month) DEC (Day) 25 (Year) 1950

5. SEX female

6. COLOR OR RACE White

7. ~~SINGLE~~, MARRIED, WIDOWED, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH ? approx.

9. AGE last birthday 82? yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife

10b. KIND OF BUSINESS OR INDUSTRY own

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown Whitman

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. NONE

17. INFORMANT Mr. Harry L Hoffman 724 Westover Ave Norfolk, Va

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) AURICULAR FIBRILATION	4 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) carbon monoxide GAS POISONING due to deposit of carbon in a gas water heater resulting in incomplete combustion of natural gas	4 days
	(c) ARTERIO-SCLEROTIC CARDIAC DISEASE	unknown

8930
178C

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) at home (CITY OR TOWN) Annapolis (COUNTY) A.A. (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) DEC. 21, 1950 ? m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? [illegible] see above 2/19/1951 akc

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M Klaffy (Degree or title) M.D. Deputy Medical Examiner ADDRESS Annapolis, Md. DATE SIGNED 12/25/50

23. BURIAL, CREMATION REMOVAL (Specify) Removal

DATE THEREOF 12-26-50

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State) Norfolk, Virginia

DATE REC'D BY LOCAL REG. Dec. 26, 1950

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR B.L.Hopping and Son ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

DEC 27 1950

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

11902

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural — LENGTH OF STAY (In this place) Annapolis
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1 mile N. of Rt 50 Rt. 301 nr Pigon House Inn

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Prince George
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Branchville,
STREET ADDRESS (If rural, give location) 5002- Cheyenne Place

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JOHN	MICHAEL	HOFFMAN JR.	December	18	50 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	3- 30- 1927	23 yrs.	8	18		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Driver	Fuel Oil Company	Mass	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Michael Hoffman Sr.	Irene Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
Yes WW II	018-14-5119	Mrs Olive V. Hoffman 5002- Cheyenne Place Branchville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) 3rd degree burns over 95% of the Body

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accident

(c)

816.5
170e

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	1 mile North Rt 301 of RT 50		Anne Arundel	Maryland

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☒	Not while at work ☐	HOW DID INJURY OCCUR?
12-18-50 7:30 A.m.			Hoffmans truck ran into the rear of another truck, turned over, caught fire, pined Him in

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John M. Cliffe M.D.	Dept Medical Examiner for Anne Arundel County	98 Gloucester St. Annapolis, Md	12-18-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	12- 20-50	Arlington National Cemet	Arlington, Va

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Dec. 19, 1950		B.L. Hopping and Son	Annapolis, Md.

42060

RECEIVED
DEC 21 1960
BUREAU V.S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

Vol BC

11903

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ELVATON
LENGTH OF STAY (in this place) LIFE
HOSPITAL OR INSTITUTION OR STREET ADDRESS ELVATON

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE 30
STREET ADDRESS (If rural give location) 509 W. CROSS ST

3. NAME OF DECEASED (Type or Print) (First) MILLIKIN (Middle) (Last) HUDSON JR

4. DATE OF DEATH (Month) 12 (Day) 7 (Year) 1950

5. SEX MALE
6. COLOR OR RACE COLORED
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH 5-31-09
9. AGE last birthday 41 yrs. If under 1 year Months 7 Days 5 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER
10b. KIND OF BUSINESS OR INDUSTRY BAKERY
11. BIRTHPLACE (State or foreign country) ELVATON, MD.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME MILLIKIN HUDSON
14. MOTHER'S MAIDEN NAME BERTHA V. MATTHEWS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-07-7546
17. INFORMANT MILLIKIN HUDSON SR. ELVATON, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — [illegible]

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

94a (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/24/50, 19....., to 12/7/50, 19....., that I last saw the deceased alive on 12/6/50, 19....., and that death occurred at 8 A m., from the causes and on the date stated above.

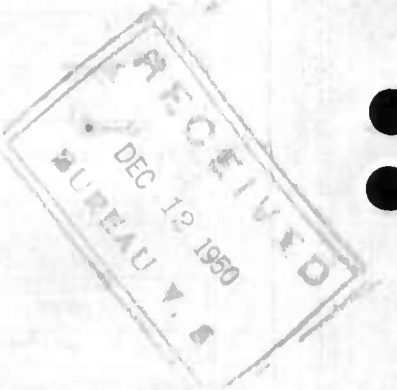
SIGNATURE John J. Alexander (Degree or title) MD ADDRESS Glen Burnie DATE SIGNED 12/9/50

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF 12-10-50
NAME OF CEMETERY OR CREMATORY HALLS CHURCH
LOCATION (City, town, or county) (State) MARLEY, A.A. CO. MD.

DATE REC'D BY LOCAL REG. 12/9/50
REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR Wm. A. JACKSON. ADDRESS 916 PENNA. AVE. BALTIMORE 1. MD.

988 XV


RECEIVED
DEC 19 1950
BUREAU V.

11904

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 408 Adams

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural, give location) 408 Adams

3. NAME OF DECEASED (Type or Print) (First) Walter (Middle) W. (Last) Hurlock

4. DATE OF DEATH (Month) 12 (Day) 4 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH Mar 27 1876
9. AGE last birthday 74 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Patton Maker
10b. KIND OF BUSINESS OR INDUSTRY N.S.N. Academy
11. BIRTHPLACE (State or foreign country) Hurlock Md.
12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Spanish American Wr
16. SOCIAL SECURITY No. —
17. INFORMANT AND ADDRESS Mamie W. Hurlock Eastport Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.0	Immediate cause	(a) Heart Block	1 wk.
93d	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic Heart disease	8 yrs.
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb., 1946, to Dec. 4, 1950, that I last saw the deceased alive on Dec. 3, 1950, and that death occurred at 5 00 a.m., from the causes and on the date stated above.

SIGNATURE James R. Martin (Degree or title) M.D. ADDRESS Annapolis, Md. DATE SIGNED 12-5-50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify)
DATE THEREOF 12-7-50
NAME OF CEMETERY OR CREMATORY Cedar Bluff
LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. Dec. 6, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Lay Co. Inc. ADDRESS Annapolis Md.

34497

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

RECEIVED
DEC 7 1950
U.S. VETERANS BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11905

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY A. A. Co., Md. — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN — LENGTH OF STAY (in this place) — HOSPITAL OR INSTITUTION OR STREET ADDRESS Marley Neck, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Marley Neck. — STREET ADDRESS (If rural, give location) Marley Neck

3. NAME OF DECEASED (Type or Print): (First) ADA (Middle) (Last) JOHNSON

4. DATE OF DEATH: (Month) DECEMBER (Day) 20 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: July 29, 1903

9. AGE last birthday: 47 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): A. A. Co. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Steven Harris.

14. MOTHER'S MAIDEN NAME: Emma Jackson.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Timothy Johnson. Marley Neck, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) CEREBRAL HEMORRHAGE — 3 days

443 X 93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio Vascular Disease — 6 years

(c) Arteriosclerotic Cardio-Vascular Disease — 6 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 0

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1950, to Dec. 20, 1950, that I last saw the deceased alive on Dec 20, 1950, and that death occurred at 9:15P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

G. Brady Smith M.D. Riviera Beach, Md. 12/20/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 12-24-1950 — NAME OF CEMETERY OR CREMATORY: Magothy — LOCATION (City, town, or county) (State): Magothy, Md.

DATE REC'D BY LOCAL REG.: December 23-1950 — REGISTRAR'S SIGNATURE: R W.

24. FUNERAL DIRECTOR — ADDRESS: Mrs. K. R. Williams 322 N. Schroeder St.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

11906

Reg. Dist. No. .....

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Patapsco Park
LENGTH OF STAY (in this place) 3 mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5809 Belle Grove

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Patapsco Park
STREET ADDRESS (If rural, give location) 5809 Belle Grove Road.

3. NAME OF DECEASED (Type or Print) (First) GEORGE (Middle) EDWARD (Last) JOHNSON, JR

4. DATE OF DEATH (Month) DEC. (Day) 20 (Year) 1950

5. SEX MALE
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH Sept. 19. 1950
9. AGE last birthday yrs. If under 1 year: Months 3 Days 1 If under 24 hrs: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George Edward Johnson Sr.
14. MOTHER'S MAIDEN NAME Catherine Watson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS George Edward Johnson Sr., Patapsco Park

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) BURNED IN HOME FIRE

916.0

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) TRAPPED IN BURNING HOUSE

180

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home (CITY OR TOWN) Patapsco Park (COUNTY) A.A. (STATE) Md.
TIME OF INJURY (Month) Dec. (Day) 20 (Year) 1950 (Hour) 12:30 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR? Trapped in Burning home.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Caffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 12/20/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 12/21/50
NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery
LOCATION (City, town, or county) A.A. Co. Md. (State)

DATE REC'D BY LOCAL REG. 12/21/50
REGISTRAR'S SIGNATURE D.W. Hedrick
24. FUNERAL DIRECTOR Charles R. Law ADDRESS 802 Madison Ave

2-29-19-0-19 -1-40-3 DM

VS. A15A

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

#50-1987X

M

I

Birthplace 5 Hon

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

11907

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) [illegible]
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parole
STREET ADDRESS (If rural, give location) 1933 West

3. NAME OF DECEASED (Type or Print): (First) JOSEPH (Middle) ARTHUR (Last) JOHNSON

4. DATE OF DEATH: (Month) Dec. (Day) 26 (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE

8. DATE OF BIRTH: AUG 10 1917

9. AGE last birthday: 33 yrs. If under 1 year: Months / Days. If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Naval Academy

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY: U.S.A

13. FATHER'S NAME: Thomas Johnson

14. MOTHER'S MAIDEN NAME: Edith Gonzo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service: WW II

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs. Edith S. Johnson. 1933 West St Parole Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	1 hour
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	2 about years
	(c)	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

John McLeffy M.D. Deputy Medical Examiner | Annapolis Md | 12/26/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF Dec 31, 1950 | NAME OF CEMETERY OR CREMATORY Brewers Hill | LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. Dec. 29, 1950 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR J.B. Johnson | ADDRESS Annapolis, Md.

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RECEIVED
DEC 30 1950
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

11908

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena P.O. — LENGTH OF STAY (In this place) 15 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mountain Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena P.O.,
STREET ADDRESS (If rural, give location) Mountain Road.

3. NAME OF DECEASED (Type or Print): (First) RUTH (Middle) CATHERINE (Last) JONES

4. DATE OF DEATH: (Month) DEC. (Day) 28 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, ~~WIDOWED~~ ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: Aug 23 1905

9. AGE last birthday: 45 yrs. — If under 1 year: Months / Days — If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: W. J. McCarran

14. MOTHER'S MAIDEN NAME: Lydia Chandler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Frederick Jones

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cardiac Asthma	Sudden
422.2 **Antecedent cause(s)** 93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis	5 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

John M. Claffy M.D. Deputy Medical Examiner, Annapolis Md. 12/28/50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 12-30-50 — NAME OF CEMETERY OR CREMATORY Cedar Hill — LOCATION (City, town, or county) (State) Brooklyn R.F.D., Md.

DATE REC'D BY LOCAL REG. 12/30/50 — REGISTRAR'S SIGNATURE L. J. Dorsch — 24. FUNERAL DIRECTOR R. V. Singleton — ADDRESS Glen Burnie, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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JAN 2 1951
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 27

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort George G Meade
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. ARMY HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
STREET ADDRESS (If rural, give location) Box 9 AA Rt # 1

3. NAME OF DECEASED (Type or Print): (First) JAMES (Middle) JOSEPH (Last) KENNEDY

4. DATE OF DEATH: (Month) December (Day) 29 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 1 Oct 1880

9. AGE last birthday: 70 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: U.S. army

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: -

17. INFORMANT AND ADDRESS: Mrs Kennedy (W)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0 **Immediate cause** (a) Arteriosclerotic heart disease with decompensation

930 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral arteriosclerosis with hemiplegia

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on 29 Dec, 1950, and that death occurred at 0530 hrs m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Harley B. Messinger
HARLEY B. MESSINGER, Lt JG MC USNR — U. S. ARMY HOSP FT MEADE, MD — 29 Dec 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 2 Jan 51 — NAME OF CEMETERY OR CREMATORY: Arlington National — LOCATION (City, town, or county) (State): Arlington, Virginia

DATE REC'D BY LOCAL REG.: 29 Dec 50 — REGISTRAR'S SIGNATURE: E. K. BURNSIDE, CAPT., MSC

24. FUNERAL DIRECTOR — ADDRESS: Gasch, William F. Hyattsville, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11910

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville | LENGTH OF STAY (in this place) 14 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) not known

3. NAME OF DECEASED (Type or Print): (First) Bertha (Middle) (Last) Kent
4. DATE OF DEATH (Month) (Day) (Year): 12/12/50 19

5. SEX: female
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed
8. DATE OF BIRTH: ~~not known~~ about 1896
9. AGE last birthday: 54 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: not known
14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or ~~unknown~~) (If yes give war or dates of service) XXXX

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

11911

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Mollie Neack MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN R F D I Box 99 A
LENGTH OF STAY (In this place) Unkown
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sollery Rd

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md COUNTY A.A.Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mollie Neack
STREET ADDRESS (If rural, give location) Sollery Rd

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Joseph	C.	Kess	I2	3	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Male	Col.	Married	3/Io/I880	70 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer Farmowner	Farming	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
? Kess	Unkown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No		Bessie Kess Mollie Neack Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
450.0 Immediate cause	(a) Congestive heart failure	9 months
Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteriosclerosis	Not Known
	(c) anasarca	3 months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Dey) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Oct. 15, 1949, to Dec. 3, 1950, that I last saw the deceased alive on Dec 1, 1950, and that death occurred at 12 M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C. M. McLaughlin	M.D.	Pasadena P.O., Md.	Dec. 4, 1950

23. BURIAL, CREMATION / REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	12-7-1950		Anundle Co Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
12/6/50	A. W. Nelson	Elroy O. Wilson	1000 Brantley Ave

Dr Klaware

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11912

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

(I)

1. PLACE OF DEATH · COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN: Annapolis — LENGTH OF STAY (in this place): 18	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 121 West Street	STREET ADDRESS (If rural, give location): 121 West Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JOSEPH	W	KING	Dec	27	50 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Widowed	Aug. 9, 1877	73 yrs.	4 / 18	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Dairy Store	Calvert County, Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John F. King	Virginia Phipps

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No — No	214-05-0604	Mrs Joseph Peddicord West St. Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Occlusion	Instantaneous
420.1 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic C.V. Disease	10 yrs +
93d	(c) Arteriosclerotic Cerebral Disease	10 yrs +
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
—	—	—	—	—

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
— m.	—	—

22. I hereby certify that I attended the deceased from Dec 27, 1945, 19....., to Dec 27, 1950, that I last saw the deceased alive on Oct. 12, 1950 and that death occurred at 4 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Maurice F Klaware, MD	Annapolis, Md	Dec 29, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	12-30-50	Edwards Chapel	Parole, Anne Arundel, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Dec. 29, 1950	[signature]	B.L.Hopping and Son	Annapolis, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Galesville — LENGTH OF STAY (in this place) 61 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Galesville
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Naomi (Middle) (Last) Kolb				4. DATE OF DEATH (Month) (Day) (Year) Dec. 18, 1950 19	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Feb. 4, 1889	9. AGE last birthday 61 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY General Store	11. BIRTHPLACE (State or foreign country) Galesville, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John J. Kolb			14. MOTHER'S MAIDEN NAME Caroline Kirchner		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	(If year, give war or dates of service)	16. SOCIAL SECURITY NO. 217-03-9202	17. INFORMANT AND ADDRESS C. Francie Kolb, Galesville, Md.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Occlusion

420.1 Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerosis.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 17, 1950, to Dec 18, 1950, that I last saw the deceased alive on Dec 18, 1950, and that death occurred at 3.45 P.M. from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Emily H. Wilson	M.D.	Lothian, Md.	12-19-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Dec. 20, 1950	NAME OF CEMETERY OR CREMATORY Quaker	LOCATION (City, town, or county) (State) Galesville, Md.
DATE REC'D BY LOCAL REG. 12/19/50	REGISTRAR'S SIGNATURE W. R. Clayton Deputy	24. FUNERAL DIRECTOR T.A. Hardesty & Son, Galesville, Md.	ADDRESS

43263

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 20 1950
U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

11914

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville; LENGTH OF STAY (in this place): 1½ years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Prince George's
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hyattsville
STREET ADDRESS (If rural, give location): 4813 Braxton Place

3. NAME OF DECEASED (Type or Print): (First) Carrie (Middle) (Last) Lancaster

4. DATE OF DEATH: (Month) 12 (Day) 29 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 12/9/98

9. AGE last birthday: 52 yrs. If under 1 year: Months — Days — If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Lynn Lucas

14. MOTHER'S MAIDEN NAME: Lucy ???

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If year, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hodgkins Disease	Known to us since 9/6/50
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

201 x
134

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

Active lung tuberculosis	6/14/50
Psychosis with Cerebral Arteriosclerosis	5/27/50

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION: — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: — (CITY OR TOWN) — (COUNTY) — (STATE) —

TIME OF INJURY (Month) (Day) (Year) (Hour) —— m. INJURY OCCURRED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from June 10, 1949, to Dec. 29 19 50, that I last saw the deceased alive on 12/29, 19 50 and that death occurred at 12:25 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Jacob Marquart M.D. ADDRESS: Crownsville, Maryland DATE SIGNED: 12/29/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE: 12-29-'50 NAME OF CEMETERY OR CREMATORY: Woodlawn LOCATION (City, town, or county) (State): Wash. N.

DATE REC'D BY LOCAL REG.: Dec 29-50 REGISTRAR'S SIGNATURE: K N Joyce

24. FUNERAL DIRECTOR: John T. Stewart ADDRESS: 30 H. St. N.E.

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KEAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

11915

Reg. Dist. No. 27

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort Geo. G. Meade — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. ARMY HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arund
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort George G. Meade
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Margurite (Middle) (Last) Leatherman

4. DATE OF DEATH: (Month) December (Day) 15 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 13 Feb 1918

9. AGE last birthday: 32 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Leipsic, Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Conn Cain

14. MOTHER'S MAIDEN NAME: Ethel Schwartz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT AND ADDRESS: Sgt Leatherman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

204.1 **Immediate cause** (a) Leukemia, myelogenous, chronic — 3 years

74a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cellulitis, right arm

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from September, 1950, to 15 Dec, 1950, that I last saw the deceased alive on 15 Dec, 1950, and that death occurred at 7:55 p.m., from the causes and on the date stated above.

SIGNATURE: W. A. Berg, Capt. MC (Degree or title) — ADDRESS: Ft Geo G. Meade, Md. — DATE SIGNED: 16 December 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 16 Dec 50 — NAME OF CEMETERY OR CREMATORY: Sugar Ridge — LOCATION (City, town, or county) (State): Leipsic, Ohio

DATE REC'D BY LOCAL REG.: 16 Dec 50 — REGISTRAR'S SIGNATURE: E.K. BURNSIDE, CAPT. MSC

24. FUNERAL DIRECTOR: Donaldson Funeral Home — ADDRESS: Laurel, Maryland

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DEC 20 1950
BUREAU U. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

11916

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) Shipton Heights

3. NAME OF DECEASED (Type or Print): (First) Iva (Middle) J. (Last) Martin

4. DATE OF DEATH: (Month) 12 (Day) 24 (Year) 1950

5. SEX: F

6. COLOR OR RACE: W.

7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~, (Specify)

8. DATE OF BIRTH: 6-18-1888

9. AGE last birthday: 62 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Churchton Md.

12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: Napolian Windsor

14. MOTHER'S MAIDEN NAME: Mary Howe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT AND ADDRESS: Raymond B. Martin Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Carcinoma Lung	1 year
170 X Antecedent cause(s) 50 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma Left Breast.	6 years
	(c)	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1950, to Dec. 24, 1950, that I last saw the deceased alive on Dec 24, 1950, and that death occurred at 5-17 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George C. Basil M. D. Annapolis Md 12-26-50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE THEREOF 12-27-50 NAME OF CEMETERY OR CREMATORY Cedar Bluff LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. Dec. 27, 1950 REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR John M. Sayles Sons Annapolis ADDRESS Md.

11917

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) Prince Leo St.

3. NAME OF DECEASED (Type or Print) (First) Margaret (Middle) Ann (Last) Martin
4. DATE OF DEATH (Month) 12 (Day) 1 (Year) 1950

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH Sept. 13th 1865
9. AGE last birthday 85 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Annapolis Md.
12. CITIZEN OF WHAT COUNTRY N. S. A.

13. FATHER'S NAME Charles W. Martin
14. MOTHER'S MAIDEN NAME Pricilla A. Branzell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT AND ADDRESS Mrs V. J. Pazzetti Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Occlusion	1 hr.
420.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(b) Arteriosclerotic Heart Disease	3 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 10, 1946, to Dec. 1, 1950, that I last saw the deceased alive on Dec. 1, 1950, and that death occurred at 6 00 p.m., from the causes and on the date stated above.

SIGNATURE James R. Martin (Degree or title) M.D. ADDRESS Annapolis, Md. DATE SIGNED 12-1-50

23. BURIAL, CREMATION REMOVAL (Specify)
DATE THEREOF Dec. 4-1950
NAME OF CEMETERY OR CREMATORY St Annes
LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. Dec. 4, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Tay Co. Sir ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 5 1960
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11918

CERTIFICATE OF DEATH

Reg. Dist. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jessups
LENGTH OF STAY (in this place) 1 Month
HOSPITAL OR INSTITUTION OR STREET ADDRESS MHC Jessups, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 1311 Argyle Avenue

3. NAME OF DECEASED (Type or Print): (First) Ernest (Middle) NMN (Last) McDonald
4. DATE OF DEATH: (Month) Dec. (Day) 11 (Year) 1950
5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH: Aug. 7 1884
9. AGE last birthday: 66 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Cameron, N. Carolina
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: MHC-Jessups, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral hemorrhage with coma & hemiplegia — 3 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Valvular heart disease

(c) Arterio-sclerosis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 8, 1950, to Dec. 11, 1950, that I last saw the deceased alive on Dec. 10 1950, and that death occurred at 3:40 A m., from the causes and on the date stated above.

SIGNATURE John A Clark (Degree or title) ADDRESS DATE SIGNED

JOHN A. CLARK, M. D., Physician in Charge, MHC Jessups, Md. 12/11/50

23. BURIAL, CREMATION REMOVAL (Specify) Removal | DATE THEREOF 12/14/50 | NAME OF CEMETERY OR CREMATORY University Med School | LOCATION (City, town, or county) (State) Balto City Md

DATE REC'D BY LOCAL REG. 12-14-50 | REGISTRAR'S SIGNATURE Clara Baslup | 24. FUNERAL DIRECTOR Frances A Hemsley | ADDRESS 578 N Bradford

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

11919

Reg. Dist. No. 21

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Annapolis — LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Weems Creek

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: A A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Annapolis
STREET ADDRESS (If rural, give location): Weems Creek

3. NAME OF DECEASED (Type or Print): (First) CARL (Middle) (Last) MOHLER

4. DATE OF DEATH: (Month) DEC. (Day) 8 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, ~~(Specify)~~

8. DATE OF BIRTH: 7-11-1889

9. AGE last birthday: 61 yrs. — If under 1 year: Months / Days — If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gardner Kanal U.A. Golf Course

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Switzerland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Mohler

14. MOTHER'S MAIDEN NAME: Rosalie Trider

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 212-14-5131

17. INFORMANT AND ADDRESS: Mrs. Nellie Mohler Weems Creek A.A. Co. Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion.	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	unknown
	(c)	

420.1

94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: John M. Claffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS: Annapolis, Md DATE SIGNED: 12/9/50

23. BURIAL, ~~CREMATION~~, ~~REMOVAL (Specify)~~ DATE THEREOF: 12-11-50 NAME OF CEMETERY OR CREMATORY: St Annes Cemetery LOCATION (City, town, or county): Annapolis (State): Md

DATE REC'D BY LOCAL REG.: Dec. 11, 1950 REGISTRAR'S SIGNATURE: [signature] 24. FUNERAL DIRECTOR: John M. Taylor Son ADDRESS: Annapolis Md.

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DEC 13 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

11920

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton | LENGTH OF STAY (In this place) All his life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A-A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton
STREET ADDRESS (If rural, give location) Rural

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) (Last) OFFER
4. DATE OF DEATH: (Month) Dec. (Day) 26 (Year) 1950

5. SEX: Male | 6. COLOR OR RACE: Negro | 7. ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify) | 8. DATE OF BIRTH ~~(Month) (Day)~~ (Year) 1874 | 9. AGE last birthday dont 76 yrs. | If under 1 year: Months, Days | If under 24 hrs: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Oysterman. | 10b. KIND OF BUSINESS OR INDUSTRY: Sea food | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Offer | 14. MOTHER'S MAIDEN NAME: Cyrena Dennis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service): no | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS: Cyrena Prowner, Shady Side Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Dilatation of Heart	Sudden
443X 93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Cardiac disease	unknown
	(c) arterio-sclerosis	"

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wm. M. Beatty	M.D. Deputy Medical Examiner	Annapolis Md	12/27/50

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	Dec 29-1950	Franklin Mem.	Churchton	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
12/29/50	D.K. Clayton	J.C. Hardesty & Son	Galesville Md.

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11921

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH· COUNTY Browns Woods AA MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE Browns Woods COUNTY AA
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN / LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Patrick Pearman (Middle) (Last)			4. DATE OF DEATH (Month) 12 (Day) 30 (Year) 1950		
5. SEX M	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH 9-~~12~~ 10-50	9. AGE last birthday yrs.	If under 1 year Months 5 Days / If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Baltimore City Md.	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Patrick Pearman			14. MOTHER'S MAIDEN NAME Rosetta Blunt		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Alma H. Pearman		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Broncho-pneumonia	about 6 days
491x Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause lest	(b)	
107	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) Annapolis	(COUNTY) Md (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 12-28, 1950, to 12-29, 1950, that I last saw the deceased alive on 12-29, 1950, and that death occurred at 11 45 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
A. J. Allen	M D	10 Carroll	x 12-1-50

23. BURIAL, CREMATION REMOVAL (Specify) B	DATE THEREOF 1-1-51	NAME OF CEMETERY OR CREMATORY Broad Neck	LOCATION (City, town, or county) Broad Neck (State) Md.
DATE REC'D BY LOCAL REG. Jan. 1, 1951	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR William Reese	ADDRESS 108 Wash. St. Annapolis, Md.

2-09-10-0-24-2-40-5

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

50-19387

Birth weight 3 10 grams

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

11922

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place) 20 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
HOSPITAL OR INSTITUTION OR STREET ADDRESS 26 Randell Street	STREET ADDRESS (If rural, give location) 26 Randell St.

3. NAME OF DECEASED (Type or Print)	(First) William	(Middle) A.	(Last) QUINN	4. DATE OF DEATH	(Month) December	(Day) 25	(Year) 1950
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Seperated	8. DATE OF BIRTH Oct. 31, 1872	9. AGE last birthday 78 yrs.	If under 1 year Months 1	Days 24	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor	10b. KIND OF BUSINESS OR INDUSTRY barrell Manf.	11. BIRTHPLACE (State or foreign country) New Port R.I	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Patrick Quinn	14. MOTHER'S MAIDEN NAME Annie C. Wooley						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) nO (If yes, give war or dates of service) nO	16. SOCIAL SECURITY NO. none	17. INFORMANT AND ADDRESS Miss Mary Agnes Quinn 26 Randell St. Annapolis, Md					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Generalized Carcinomatosis

199.8 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Primary Source - Unknown

55e (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan, 1949, to Dec 25, 1950, that I last saw the deceased alive on 12-21, 1950, and that death occurred at 12:30 A m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) M.D. ADDRESS Chesapeake Av. [signature] DATE SIGNED 12/26/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 12-27-50	NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	LOCATION (City, town, or county) (State) Annapolis, Md.
DATE REC'D BY LOCAL REG. Dec 27, 1950	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR B.L. Hopping and Son	ADDRESS Annapolis, Md

21044

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11923

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural-Deale
LENGTH OF STAY (in this place) 50 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Deale Md.
STREET ADDRESS (If rural, give location) Chunchton

3. NAME OF DECEASED (Type or Print) (First) Robert (Middle) Franklin (Last) Reeves
4. DATE OF DEATH (Month) 12 (Day) 20 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH July 5th 1875
9. AGE last birthday 74 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) manager of sales
10b. KIND OF BUSINESS OR INDUSTRY life insur.
11. BIRTHPLACE (State or foreign country) PA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME David Reeve.
14. MOTHER'S MAIDEN NAME Elizabeth McIntyre
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 577-03-9119
17. INFORMANT AND ADDRESS Mrs. Nell F. Reeve - Chunchton

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebenal thrombosis — 3 hrs.

332x

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arteriosclerosis

831

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. left hemiplegia — 10 yrs.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12.19, 1950, to 12.20, 1950, that I last saw the deceased alive on 9.20.50, 19....., and that death occurred at 5:10 m., from the causes and on the date stated above.

SIGNATURE Bowie Linn Grant (Degree or title) M.D. ADDRESS Shady Side, Md. DATE SIGNED 12.20.50.

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 12/22/50
NAME OF CEMETERY OR CREMATORY Catholic Church
LOCATION (City, town, or county) Owensville, Md. (State)
DATE REC'D BY LOCAL REG. 12/21/50
REGISTRAR'S SIGNATURE [illegible] Clayton Dep. Chief
24. FUNERAL DIRECTOR T.A. Hardesty & Son ADDRESS Galesville, Md.

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11924

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. Co General

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 11 Brewer Ave

3. NAME OF DECEASED (Type or Print) (First) VAUGHAN (Middle) DEAN (Last) ROSSELL

4. DATE OF DEATH (Month) 12 (Day) 14 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH 9-10-1881
9. AGE last birthday 69 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk
10b. KIND OF BUSINESS, OR INDUSTRY U.S. Post office
11. BIRTHPLACE (State or foreign country) Macomb Ill
12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME John B. Russell
14. MOTHER'S MAIDEN NAME Henrietta Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT AND ADDRESS Caroline R. Russell Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Apoplexy — INTERVAL BETWEEN ONSET AND DEATH: Sudden

443x

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) C. Myocarditis and Arterial Hypertension — several years

93d

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 12th, 1950, to Dec 14, 1950, that I last saw the deceased alive on Dec 14, 1950, and that death occurred at 6 55 P m., from the causes and on the date stated above.

SIGNATURE J. Oliver Purvis (Degree or title) M.D. ADDRESS Annapolis Maryland DATE SIGNED 12-15-50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE THEREOF 12-17-50 NAME OF CEMETERY OR CREMATORY St Annes LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. Dec. 17, 1950 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

26695

VS. A15

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEC 21 1950
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MARYLAND STATE DEPARTMENT OF HEALTH

11925

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
LENGTH OF STAY (In this place) 16 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6 Severn Av.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural, give location) 6 Severn Av.

3. NAME OF DECEASED (Type or Print) (First) CHRIS (Middle) FINN (Last) ROSTAD
4. DATE OF DEATH (Month) 12 - (Day) 26 (Year) 1950

5. SEX MALE
6. COLOR OR RACE White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH Nov. 8, 1905
9. AGE last birthday 45 yrs. If under 1 year Months Days If under 24 hrs Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger
10b. KIND OF BUSINESS OR INDUSTRY Ship Yard
11. BIRTHPLACE (State or foreign country) Norway
12. CITIZEN OF WHAT COUNTRY U.S.A

13. FATHER'S NAME Samuel Rostad
14. MOTHER'S MAIDEN NAME not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.
16. SOCIAL SECURITY No. 087-16-3012
17. INFORMANT AND ADDRESS Mrs. Evelyn E. Rostad, 6 Severn Av. Eastport Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.1	Immediate cause	(a) Coronary occlusion	sudden
94a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	unknown
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md. DATE SIGNED 12/26/50

23. BURIAL, CREMATION, REMOVAL (Specify) Bur. DATE THEREOF 12/28/50 NAME OF CEMETERY OR CREMATORY CEDAR BLUFF LOCATION (City, town, or county) (State) ANNAPOLIS, MD.

DATE REC'D BY LOCAL REG. Dec. 27, 1950 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor & Son ADDRESS Annapolis Md.

49640

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

DEC 28 1960

11926

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH · COUNTY: Ann Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland D.C. COUNTY: Ann Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Laurel — LENGTH OF STAY (in this place): 17 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Laurel, Maryland.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: District Training School.	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) PEARL	(Middle) FRANCES	(Last) SAVOY	4. DATE OF DEATH	(Month) Dec.	(Day) 12	(Year) 1950
5. SEX: Female	6. COLOR OR RACE: C.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 7-11-02	9. AGE last birthday: 48 yrs.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Feeble-minded	10b. KIND OF BUSINESS OR INDUSTRY: None	11. BIRTHPLACE (State or foreign country): Washington, D.C.	12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME: William Savoy	14. MOTHER'S MAIDEN NAME: Matilda Butler						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.: -----	17. INFORMANT AND ADDRESS: District Training School, Laurel, Md.					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Myocarditis	10 years +
443x Antecedent cause(s)	(b) Hypertension chronic	10 years +
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Mental Deficiency	Life

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☑ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1949, to Dec. 12, 1950, that I last saw the deceased alive on Dec. 12, 1950, and that death occurred at 10:00 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
B. Sendra	M.D.	D.T.S. Laurel, Md.	12-13-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE: 12-14-50	NAME OF CEMETERY OR CREMATORY: Mt Olivet	LOCATION (City, town, or county) (State): Wash. D.C.
DATE REC'D BY LOCAL REG.: 12-14-50	REGISTRAR'S SIGNATURE: Clara Kasluf	24. FUNERAL DIRECTOR: Malvan & Schey	ADDRESS: 424 R. St NW #115

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JAN 10 1951
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

11927

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LINTHICUM HEIGHTS — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum Heights
HOSPITAL OR INSTITUTION OR STREET ADDRESS 807 CAMP MEADE RD.	STREET ADDRESS (If rural, give location) 807 Camp Meade Rd.

3. NAME OF DECEASED (Type or Print) (First) MAGGIE (Middle) M. (Last) SEVERE			4. DATE OF DEATH (Month) December (Day) 20 (Year) 1950	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W.D.	8. DATE OF BIRTH Nov. 27, 1854	9. AGE last birthday 96 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Maryland.	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Asbury Abbott		14. MOTHER'S MAIDEN NAME Augusta Love		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. no	17. INFORMANT AND ADDRESS Mrs. Nettie Severe - 807 Camp Meade Rd.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Inanition c̄ Secondary anemia	4 wks.
153X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic Heart Disease	+1 yrs
46 m	(c) Suspect Carcinoma of G-I tract	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 30, 1950, to Dec 20, 1950, that I last saw the deceased alive on Dec 20, 1950, and that death occurred at 5:20 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C. Milton Linthicum,	M.D.	Linthicum Heights, Md.	Dec. 20, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 12/23/50	NAME OF CEMETERY OR CREMATORY Balto. Cem.	LOCATION (City, town, or county) (State) Balto., Md.
DATE REC'D BY LOCAL REG. 12/21/50	REGISTRAR'S SIGNATURE R.W. Hedrick Dep	24. FUNERAL DIRECTOR Wm. J. Tickner & Sons	ADDRESS Balto Md.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11928

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville — LENGTH OF STAY (in this place): 33 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
STREET ADDRESS (If rural, give location): 1312 Parrish Street ✓

3. NAME OF DECEASED (Type or Print) (First) Hester (Middle) (Last) Simms
4. DATE OF DEATH (Month) (Day) (Year) 12/24/50 19

5. SEX: female
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: ~~unknown~~ about 1871
9. AGE last birthday: 79 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): not known
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: not known
14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic Myocarditis — known

422.1 Antecedent cause(s) — 11/22/50

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arteriosclerosis — " "

(c) — " "

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. Senile Psychosis

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): none
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour): none m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 11-22/50, 19....., to 12/24/50, 19....., that I last saw the deceased alive on 12/24/50, 19....., and that death occurred at 3 55 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Jacob Morgenstern M.D. — ADDRESS: Crownsville, Md. — DATE SIGNED: 12/24/50

23. BURIAL, CREMATION REMOVAL (Specify): Removal — DATE: 12/28/50 — NAME OF CEMETERY OR CREMATORY: University Med School — LOCATION (City, town, or county) (State): Baltimore City, Md

DATE REC'D BY LOCAL REG.: 12/28/50 — REGISTRAR'S SIGNATURE: L. J. D'Alba — 24. FUNERAL DIRECTOR: Frances A. Hemsley — ADDRESS: 578 W Biddle St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 29 1960
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

11929

Reg. Dist. No. 25

1. PLACE OF DEATH: COUNTY ANN ARUNDEL CO. MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jacobsville; LENGTH OF STAY (In this place) 5 months; HOSPITAL OR INSTITUTION OR STREET ADDRESS 20 BALLMAN COURT

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD. COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN A.A. CO Jacobsville; STREET ADDRESS (If rural, give location) 20 BALLMAN CT.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ADA	VIRGINIA	SMITH	DEC.	25	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
FEMALE	WHITE	WIDOWED	APRIL 20 1897	53 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWORK	AT HOME	RIG W. VA	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN RIGGLEMAN	ALBERTA PRATT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
		(SON) ORVILE W. SMITH 20 BALLMAN CT.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Metastatic Carcinoma of Spinal	5 mos.
142.1 Antecedent cause(s)	(b) Columm Carcinoma of Parotid Gland (Rt)	1 year
55e Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Oct 31, 1950, to Dec 25, 1950, that I last saw the deceased alive on Dec 25, 1950, and that death occurred at 1230 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Benjamin Berdanosky		5004 Ritchie Highway	1/4/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR ~~CREMATORY~~	LOCATION (City, town, or county) (State)
BURIAL	12-28-50	GLEN HAVEN	Ann Arundel County Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/2/51		James L. McCully	3914 HANOVER ST

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Cook 51239

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11930

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park; LENGTH OF STAY (in this place) 9 months.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Edgewood N. Home.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore; STREET ADDRESS (If rural, give location) 2101 - W. Cold Spring Lane.

3. NAME OF DECEASED (Type or Print): (First) Beatrice (Middle) (Last) Smith

4. DATE OF DEATH: (Month) Dec. (Day) 24 (Year) 1950

5. SEX: F.

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Sept. 1, 1869

9. AGE last birthday: 81 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alexander Neely

14. MOTHER'S MAIDEN NAME: Mary Robertson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Edgewood N. Home Records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) General arterio-sclerosis — Interval between onset and death: 9 months.

450.0 / 97 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) senility — Interval: "

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour):

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1950, to Dec. 24, 1950, that I last saw the deceased alive on 12/22, 1950, and that death occurred at 7:30 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Leonard A. Rauber M.D. Glen Burnie Md. 12/24/50.

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify): DATE THEREOF 12/28/50; NAME OF CEMETERY ~~OR CREMATORY~~: Woodlawn; LOCATION (City, town, or county) (State): Woodlawn Md.

DATE REC'D BY LOCAL REG. 12/28/50; REGISTRAR'S SIGNATURE: A. W. Hedrick

24. FUNERAL DIRECTOR: Wm. Cook, Inc. ADDRESS: 1217 N. Paul St.

JT

52086

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

11931

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; MARYLAND; LENGTH OF STAY (In this place) D.O.A.; HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A.A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (Rural, give location) 114 Market

3. NAME OF DECEASED (Type or Print): (First) KENTON (Middle) WELCH (Last) STRANGE

4. DATE OF DEATH: (Month) Dec. (Day) 28 (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify)

8. DATE OF BIRTH: Jan. 7, 1897

9. AGE last birthday: 53 yrs. | If under 1 year: Months | Days | If under 24 hrs: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Retail paint store

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Robert E. Strange

14. MOTHER'S MAIDEN NAME: Amanda M. Black

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service): Yes, World War I

16. SOCIAL SECURITY NO.: —

17. INFORMANT AND ADDRESS: R. Tunis Strange

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	unknown
	(c)	

420.1
940

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: John M. Cathy | (Degree or title) M.D. Deputy Medical Examiner | ADDRESS Annapolis Md | DATE SIGNED 12/29/50

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF 12-30-50 | NAME OF CEMETERY OR CREMATORY St Annes | LOCATION (City, town, or county) Annapolis | (State) Md

DATE REC'D BY LOCAL REG. Dec. 30, 1950 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR John H. Taylor Son | ADDRESS Annapolis Md.

15673

RECEIVED
JAN 9 1951
BUREAU Y. S

11932

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LAKE SHORE
LENGTH OF STAY (in this place) 1 YEAR
HOSPITAL OR INSTITUTION OR STREET ADDRESS BODKIN AVENUE

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTO. -
STREET ADDRESS (If rural, give location) LAKE SHORE - A.A. Co -

3. NAME OF DECEASED (Type or Print) (First) HELENA (Middle) JOHANNA (Last) THIERGARTNER
4. DATE OF DEATH (Month) DECEMBER (Day) 17 (Year) 1950
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED
8. DATE OF BIRTH 1883
9. AGE last birthday 67 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE -
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) BALTO. Co -
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME (?)
14. MOTHER'S MAIDEN NAME (?) CHRISTANI HESSE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS MR. CARROLL THIERGARTNER - LAKE SHORE, A.A. Co. -

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Arteriosclerotic Cardio Vascular Disease	10 years
443X 61 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Hypertensive Cardio Vascular Disease	10 years
	(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from February, 1950, to Dec. 17, 1950, that I last saw the deceased alive on Dec. 16, 1950, and that death occurred at 6:00 A m., from the causes and on the date stated above.

SIGNATURE J. Brady Smith (Degree or title) M.D. ADDRESS Riviera Beach, Maryland DATE SIGNED Dec 17, 1950

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL -
DATE THEREOF 12-20-50.
NAME OF CEMETERY OR CREMATORY MEADOW RIDGE MEM. -
LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. 12-20-50
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR [signature] & Sons ADDRESS Greenmount & 22nd St.

260X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

11933

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH · COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 20 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): ✓

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Joseph Thompson				4. DATE OF DEATH (Month) (Day) (Year): 12/24/50 19	
5. SEX: male	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: about 1888 ~~not known~~	9. AGE last birthday: 62 yrs.	If under 1 year: Months. Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): not known	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: Joseph Thompson		14. MOTHER'S MAIDEN NAME: not known			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ~~(If year, give war or dates of service)~~	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS: Hospital Records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Occlusion	sudden
420.1 Antecedent cause(s)	(b) General Arteriosclerosis	known since
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Schizophrenia, Paranoid Type	1/5/29

19a. DATE OF OPERATION: none	19b. MAJOR FINDINGS OF OPERATION: none	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify): none	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE): none	
TIME OF INJURY (Month) (Day) (Year) (Hour): none m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 10/13/41, 19....., to 12/24/50, 19....., that I last saw the deceased alive on 12/24/50, 19....., and that death occurred at 3 P.M. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title) ADDRESS	DATE SIGNED
Jacob Marcuse M.D.	Crownsville, Md.	12/26/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE: 12/28/50	NAME OF CEMETERY OR CREMATORY: University Med School	LOCATION (City, town, or county) (State): Balto City Md
DATE REC'D BY LOCAL REG.: 12/28/50	REGISTRAR'S SIGNATURE: L. J. De Alla	24. FUNERAL DIRECTOR: Frances A Hemsley 578 W Biddle St	ADDRESS

XUX99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 29 1950
BUREAU

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11934

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Linthicum
LENGTH OF STAY (in this place) 1.4 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Linthicum
STREET ADDRESS (If rural, give location) Furnace Branch Rd

3. NAME OF DECEASED (Type or Print) (First) William (Middle) Plumma (Last) Thompson Sr
4. DATE OF DEATH (Month) Dec (Day) 10 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH June 28, 1885
9. AGE last birthday 65 yrs. If under 1 year: Months | Days. If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Press Operator
10b. KIND OF BUSINESS OR INDUSTRY Nat'l Enam & Stamping Co
11. BIRTHPLACE (State or foreign country) Balto
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Wm. Plumma Thompson
14. MOTHER'S MAIDEN NAME Evangeline Benton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY No. 212-10-7804
17. INFORMANT AND ADDRESS Marguerite M. Thompson Furnace Branch Rd

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Metastatic Carcinoma	6 mos
151 x Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 46 b	(b) Carcinoma of Stomach	1 yr
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10, 1950, to Dec 10, 1950, that I last saw the deceased alive on Dec 10, 1950, and that death occurred at 7-40 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Bryan Berdiansky
ADDRESS 500 X Ritchie Hwy
DATE SIGNED 12-11-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Dec 13, 1950
NAME OF CEMETERY OR CREMATORY Cedar Hill
LOCATION (City, town, or county) A.A. Co (State) Md

DATE REC'D BY LOCAL REG. 12/12/50
REGISTRAR'S SIGNATURE A. W. Hedrick
24. FUNERAL DIRECTOR A. Howard Evans
ADDRESS 1400 S Charles St

49630

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

11935

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A.A. Md MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Arthur (Middle) (Last) Trader
4. DATE OF DEATH (Month) 12 (Day) 18 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH Sept 4-1881
9. AGE last birthday 69 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk at Maryland Land Office
10b. KIND OF BUSINESS OR ~~INDUSTRY~~ Attorney
11. BIRTHPLACE (State or foreign country) Salisbury Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Allison Trader
14. MOTHER'S MAIDEN NAME Ida Thomas Williams
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT AND ADDRESS Allison Trader - Arnold P.O. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	24 hours
422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(b) Cardio-Vascular Disease	5 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐ —
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Jan., 1948, to Dec. 18, 1950, that I last saw the deceased alive on Dec 18, 1950, and that death occurred at 6 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) James S. Billingsley M.D. ADDRESS 108 Central Av. Glen Burnie Md DATE SIGNED

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify)
DATE THEREOF 12/21/50
NAME OF CEMETERY OR CREMATORY CEDAR Bluff
LOCATION (City, town, or county) (State) Annapolis, Md.
DATE REC'D BY LOCAL REG. Dec. 21, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Taylor & Son ADDRESS Annapolis, Md.

V2693

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 23 1950
BUREAU V.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11935

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laurel
LENGTH OF STAY (in this place) 2 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS District Training School

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE ~~Maryland~~ D.C. COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laurel
STREET ADDRESS ------- (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) PAUL (Middle) ALLEN (Last) TRUITT

4. DATE OF DEATH (Month) Dec. (Day) 13 (Year) 1950

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH 10-8-47

9. AGE last birthday 3 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Feeble-minded

10b. KIND OF BUSINESS OR INDUSTRY ------

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Joseph Samuel Truitt

14. MOTHER'S MAIDEN NAME Georgiana Esther Boggs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) No

16. SOCIAL SECURITY No. -------

17. INFORMANT AND ADDRESS District Training School, Laurel, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pneumonia (bilateral)	2 days
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Mental Deficiency	Life

490x

109

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-8-47, 19.., to Dec. 13, 1950, that I last saw the deceased alive on Dec. 13, 1950, and that death occurred at 4:25 p. m., from the causes and on the date stated above.

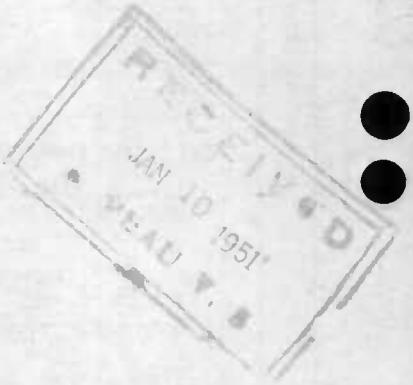
SIGNATURE B. Schultz M.D. (Degree or title) ADDRESS District Training School Laurel Md. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) DATE 12-16-50 NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem LOCATION (City, town, or county) Pr. Geo. Co. Md. (State)

DATE REC'D BY LOCAL REG. 12-14-50 REGISTRAR'S SIGNATURE Clara Haslup

24. FUNERAL DIRECTOR Deal Funeral Home 4812 Ga Ave. Wash ADDRESS

803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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11937

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
LENGTH OF STAY (in this place) 5 years.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Dorsey Road.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia COUNTY Hanover.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Peaks
STREET ADDRESS (If rural, give location) R.F.D.

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) Henry (Last) Turnstall
4. DATE OF DEATH (Month) Dec. (Day) 4 (Year) 1950

5. SEX Male
6. COLOR OR RACE Colored.
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify) Married
8. DATE OF BIRTH 12/12/76
9. AGE last birthday 73 ~~75~~ yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Railroad Employee.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) King & Queen County, Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Nathan Turnstall
14. MOTHER'S MAIDEN NAME Emeline Turnstall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Mrs. Muriel Johnson (Daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) General Arterio Sclerosis	5 y.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Senility	5 y.
	(c)	

450.0
97

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1946, to Dec. 1st, 1950, that I last saw the deceased alive on Dec. 1st, 1950, and that death occurred at 10 P.M., from the causes and on the date stated above.

SIGNATURE Gustave H. Faubert (Degree or title) M. ADDRESS Glen Burnie, Md. DATE SIGNED 12/5/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 12/8/50
NAME OF CEMETERY OR CREMATORY Virginia
LOCATION (City, town, or county) (State) King & Queens Co, Va.

DATE REC'D BY LOCAL REG. 12/6/50
REGISTRAR'S SIGNATURE A. W. Hedrich
24. FUNERAL DIRECTOR Geo. G. Kelson ADDRESS

MSV 49647 1303 Presstman St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

11938

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. Co. General Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A. Co.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN West Annapolis; STREET ADDRESS (If rural, give location) 14 Revelle

3. NAME OF DECEASED (Type or Print): (First) William (Middle) J. (Last) Vanous

4. DATE OF DEATH: (Month) 12 (Day) 11 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~, (Specify): —

8. DATE OF BIRTH: 6/11/1884

9. AGE last birthday: 66 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Wholesale Confections

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Overtona Minn.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Vanous

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Wife Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial Infarction, Acute	12 hrs.
420.0 93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic Heart Disease	2 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: INJURY OCCURRED While at Work ☐ Not While At work ☐: HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October, 1948 to Dec. 11, 1950, that I last saw the deceased alive on 12-11, 1950, and that death occurred at 12 38 p.m., from the causes and on the date stated above.

SIGNATURE: James R. Martin (Degree or title) M.D. ADDRESS: Annapolis, Md. DATE SIGNED: 12/12/50

23. ~~BURIAL~~, CREMATION, ~~REMOVAL (Specify)~~: DATE THEREOF 12-14-1950; NAME OF CEMETERY OR CREMATORY: Fort Lincoln; LOCATION (City, town, or county) (State): Prince George Co. MD.

DATE REC'D BY LOCAL REG.: Dec. 13, 1950; REGISTRAR'S SIGNATURE: M. A. Dorsch

24. FUNERAL DIRECTOR: John M. Taylor Son; ADDRESS: Annapolis MD.

15661

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 14 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11939

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: ANNE ARUNDEL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ANNAPOLIS, MD.
LENGTH OF STAY (in this place): 15 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: USNH ANNAPOLIS, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ANNAPOLIS
STREET ADDRESS (If rural, give location): St. MARGARETS MARYLAND

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
MARIE	FUCH	VINSON	12	10	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
FEMALE	WHITE	[illegible]	11-28-1894	56 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H-WIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: PHILLIAM WALL
14. MOTHER'S MAIDEN NAME: WILHEMINE RETYLAFF

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT AND ADDRESS: HUSBAND

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) CARDIAC DECOMPENSATION	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) BREAST CARCINOMA WITH METOSTASES	19 Months
	(c)	

170X
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II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-25, 1950, to 12-10, 1950, that I last saw the deceased alive on 12-10, 1950, and that death occurred at 0640 m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Keith M. Lowes dol	LTJG. MC	USNH, ANNAPOLIS, MARYLAND	10 December 1950

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	12-13-50	Maryland Academy Cemet	Annapolis	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Dec. 11, 1950	[illegible]	John M. Taylor Sons	Annapolis Md.

RECEIVED
DEC 13 1950
BUREAU V. S.

11940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH · COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 8 mos. two weeks	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): not known 233 Douglas Court

3. NAME OF DECEASED (Type or Print)	(First) Mary	(Middle) S.	(Last) Wallace	4. DATE OF DEATH	(Month) 12/1 (Day) 1950 (Year) 19
5. SEX: Female	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: 2-22-1875	9. AGE last birthday: 75 yrs.	If under Months / 1 year Days / If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY: None	11. BIRTHPLACE (State or foreign country): Calvert Co. - Md.	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME: unknown	14. MOTHER'S MAIDEN NAME: Mary Dennis				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: None.	17. INFORMANT AND ADDRESS: Joseph Wallace - 233 Douglas Court			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Generalized arteriosclerosis

422.1 Antecedent cause(s) (b) Chronic hypocarditis

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 5, 1950, to Dec. 1, 1950, that I last saw the deceased alive on December 1, 1950 and that death occurred at 3:05 A.M. m., from the causes and on the date stated above.

SIGNATURE: Jacob Morgenstern (Degree or title) M.D. — ADDRESS — DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 12-5-50	NAME OF CEMETERY OR CREMATORY: Mt. Auburn	LOCATION (City, town, or county) (State): Balto.
DATE REC'D BY LOCAL REG.: 12/4/50	REGISTRAR'S SIGNATURE: A. W. Hedrick	24. FUNERAL DIRECTOR: W. B. Griggs	ADDRESS: 1394 Hamburg St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11941

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN (Rural) Odenton Md. | LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Francis Sta. Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton (Rural)
STREET ADDRESS (If rural, give location) Francis Sta. Road.

3. NAME OF DECEASED (Type or Print): (First) Allen (Middle) W. (Last) Warfield
4. DATE OF DEATH: (Month) Dec. (Day) 30, (Year) 1950

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: March 10, 1866
9. AGE last birthday: 84 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter (retired)
10b. KIND OF BUSINESS OR INDUSTRY: Cabinetmaker
11. BIRTHPLACE (State or foreign country): Odenton, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Allen Warfield
14. MOTHER'S MAIDEN NAME: Edith Disney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Mrs. Glenn F. Swank; Odenton, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Lobar Pneumonia — 1 week

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) II Cardio Vascular Disease
(c) II Generalized Arteriosclerosis

490x1
108

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY —
(CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. —
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Dec 23, 1950 to Dec 30, 1950 that I last saw the deceased alive on Dec 29, 1950 and that death occurred at 10 20A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) John Labate M.D. ADDRESS Odenton Md. DATE SIGNED Dec 30-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Jan. 2, 1950
NAME OF CEMETERY OR CREMATORY: Waugh Chapel
LOCATION (City, town, or county) (State): Odenton, Md. (Rural)

DATE RECD BY LOCAL REG. 1/2/51
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR: Thomas W. Singleton, Glen Burnie, Md.

30849

RECEIVED
JAN 3 1951

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

11942

Reg. Dist. No. 22

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jessups. — LENGTH OF STAY (In this place) 2 1/2 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Md House of Correction

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 1112 N. Brentwood Ave. ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Fred		Thedbee	Dec.	1	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	5/16/16	34 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Driver	Truck Driver.	Petersburg, Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edward Thedbee ?	?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		Md. House of Correction Record.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420.1 **Immediate cause**	(a) Coronary Occlusion	sudden
94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Gustav H. Paulsen M.D.	County Medical Examiner	Glen Burnie Md.	12/1/50.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal	12-2-50	Niles Ohio	Niles Ohio

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
12-2-50	Dora Koshyk	Earl B. Wolverton	403 E 25th St.

42085

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
DEC 8 1950
U.S. BUREAU

12824

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Gr. A. Gambrills MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Gambrills Md
LENGTH OF STAY (in this place) 15 Jun
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Gambrills Md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) HUGH (Middle) BROCK (Last) WHITE

4. DATE OF DEATH (Month) DEC (Day) 20 (Year) 1950

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Oct 24, 1877

9. AGE last birthday 73 yrs. If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Sargent

10b. KIND OF BUSINESS OR INDUSTRY U.S.A. Army

11. BIRTHPLACE (State or foreign country) Unknown

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Amanda Brock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) War I

16. SOCIAL SECURITY No. —

17. INFORMANT AND ADDRESS Evelyn White Gambrills MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Coronary Occlusion	2 Hrs.
Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Cardio-Vascular Disease	14 Years.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1946, to Dec 20, 1950, that I last saw the deceased alive on Dec 19, 1950, and that death occurred at 6:00 A.m., from the causes and on the date stated above.

SIGNATURE Edward J Sherritt (Degree or title) M.D. ADDRESS Gambrills Md DATE SIGNED 12-20-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE Dec 23-1950 NAME OF CEMETERY OR CREMATORY Severn Cross Road LOCATION (City, town, or county) (State) Md

DATE REC'D BY LOCAL REG. 12-21-50 REGISTRAR'S SIGNATURE K. M. Joyce

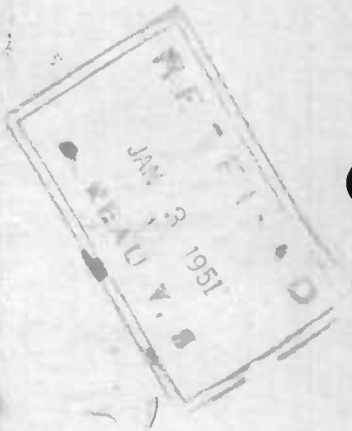
24. FUNERAL DIRECTOR Roy W Barber Laytonsville Md ADDRESS

60896

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15


JAN 3 1951

11943

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Tracy's Landing
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Brenda (Middle) E. (Last) Wills
4. DATE OF DEATH (Month) Dec. (Day) 27 (Year) 1950
5. SEX female
6. COLOR OR RACE negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH May 23, 1950
9. AGE last birthday 7 months yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) A. A. Co. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Myral Wills
14. MOTHER'S MAIDEN NAME Delores Easton
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) no
16. SOCIAL SECURITY No. none.
17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Malnutrition and dehydration

770.0 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) anemia

161c (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 26, 1950, to Dec 27, 1950, that I last saw the deceased alive on Dec 26, 1950, and that death occurred at 5:30 a. m., from the causes and on the date stated above.

SIGNATURE Emily H. Wilson (Degree or title) M.D. ADDRESS Lothian, Md. DATE SIGNED 12-27-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE Dec. 29, 1950 NAME OF CEMETERY OR CREMATORY Coopers LOCATION (City, town, or county) (State) Hallscreek, Md.

DATE REC'D BY LOCAL REG. Dec. 29, 1950 REGISTRAR'S SIGNATURE [signature] French
24. FUNERAL DIRECTOR J.B. Johnson ADDRESS Annapolis, Md.

2-0-5-25-0-2-2-40-4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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DEC 30 1950
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-1

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11944

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH · COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: At Large
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 13 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Maryland House of Correction
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First) Edward (Middle) (Last) Young			4. DATE OF DEATH (Month) (Day) (Year) 12/24/50 19		
5. SEX: male	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married	8. DATE OF BIRTH: 1/5/1907	9. AGE last birthday: 43 yrs.	If under 1 year: Months. Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): bricklayer	10b. KIND OF BUSINESS OR INDUSTRY: none		11. BIRTHPLACE (State or foreign country): Galveston, Texas	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: Not known			14. MOTHER'S MAIDEN NAME: not known		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS: Hospital Records		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
350x Immediate cause	(a) Cerebral Hemorrhage	known since 12/23/50
Antecedent cause(s) 83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Paralysis Agitans	" since 12/14/50
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Psychosis with Cerebral Arteriosclerosis	" "

19a. DATE OF OPERATION: none	19b. MAJOR FINDINGS OF OPERATION: none	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify): none	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE): none	
TIME OF INJURY (Month) (Day) (Year) (Hour): none m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 12/14/50, 19....., to 12/24/50, 19....., that I last saw the deceased alive on 12/24/50, 19....., and that death occurred at 2 P.M. m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern M.D.	Crownsville, Md.	12/26/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	12/30/50	Mt. Auburn	Baltimore, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
December 30 1950	R.W.	Wm. A. Jackson - 916 Penna. Ave	Baltimore 1. Md.

30609